American National Life Insurance Company of Texas
(herein called the "Reinsurer")

EMPLOYER DISCLOSURE STATEMENT

Employer Name:_____ Proposed Effective Date:_____

Should you require additional space to complete this form, please use the reverse side of this form or attach a separate sheet of paper. If a field does not apply please indicate with N/A.

1. List those employees who are currently not actively-at-work and/or will not be actively-at work on the coverage date, if later.

Employee Name	Claimant Name (or same)	Claimant Date of Birth	Date Last Worked	Diagnosis	Prognosis	Claims Paid	Claims Pending

2. Lists all covered individuals including dependents thereof who is currently hospital confined or are scheduled to be hospital confined on the effective date or later. The list must include active employees, COBRA and COBRA eligible individuals, IRS 1099 employees, covered retirees, and all their dependents who are eligible for coverage.

Employee Name	Claimant Name (or same)	Claimant Date of Birth	Date Disabled	Diagnosis	Prognosis	Claims Paid	Claims Pending

3. List all COBRA and COBRA eligible individuals.

Employee Name	Claimant Name (or same)	Claimant Date of Birth	Date Disabled	Diagnosis	Prognosis	Claims Paid	Claims Pending

4. List all IRS 1099 employees including dependents thereof.

Employee Name	Claimant Name (or same)	Claimant Date of Birth	Date Disabled	Diagnosis	Prognosis	Claims Paid	Claims Pending

5. List all covered retirees including dependents thereof.

Employee Name	Claimant Name (or same)	Claimant Date of Birth	Date Disabled	Diagnosis	Prognosis	Claims Paid	Claims Pending

6. List all covered persons including dependents thereof who have incurred medical expenses in excess of 50% of the specific deductible (paid or pending for COB, subrogation or miscellaneous reasons) in the last 12 months.

Employee Name	Claimant Name (or same)	Claimant Date of Birth	Date Disabled	Diagnosis	Prognosis	Claims Paid	Claims Pending

7. List all covered persons including dependents thereof who have had hospital admission pre-certification notification made within the most recent 90 days.

Employee Name	Claimant Name (or same)	Claimant Date of Birth	Nature of the Admission	Date of Admission	Number of Days Authorized	Number of Days Spent in the Hospital	Prognosis

8. List all covered persons including dependents thereof who are currently in case management or who may have been in case management at some time during the current plan year.

Employee Name	Claimant Name (or same)	Claimant Date of Birth	Date Disabled	Diagnosis	Prognosis	Claims Paid	Claims Pending

9. Other than those individuals listed above, please list any other covered person (a) for which medical expenses are expected to reach or exceed 50% of the specific deductible and/or (b) that is known to have any of the following conditions: AIDS, ARC, HIV Positive, all types of cancer including leukemia, severe cardiovascular disease including cardiomyopathy, any severe disorder of a major organ system, severe burns, major trauma, brain or spinal cord injury, any form of paralysis, high risk pregnancy, premature birth, multiple congenital anomalies, diabetes, end stage renal disease or Hepatitis C and/or (c) which has a major surgical operation anticipated or planned, or is a potential organ transplant candidate, or requires treatment with a High-Cost Drug as described below.

   A High-Cost Drug is defined as a drug for which monthly costs exceed $10,000. Examples include, but are not limited to: Avastin, Berinert, Cinryze, Daklinza, Epclusa, Firazyr, Gleevec (Imatinib), H.P. Acthar, Harvoni, Humira, Ibrance, Iclusig, Kalbitor, Kalydeco, Keytruda, Kynamro, Lumizyme, Opdivo, Orkambi, Soliris, Solvaldi, Stelara, Taltz, Technivie, Tyvaso, Uptravi, Ventavis, Viekira, Xyrem, Yervoy, Zaltrap and Zepatier.

   Conditions leading to use of High-Cost Drugs may include, enzyme deficiencies (genetic mutations, Hereditary Angio-Edema, Hunter's Syndrome and others), various cancers, Cystic Fibrosis, Multiple Sclerosis, Nephrotic Syndrome, Psoriasis and other inflammatory conditions, Hepatitis C, Hemophilia A, B & C, Hemolytic Uremia Syndrome, MDS, Narcolepsy and Pulmonary Arterial Hypertension.

Employee Name	Claimant Name (or same)	Claimant Date of Birth	Date Disabled	Diagnosis	Prognosis	Claims Paid	Claims Pending

We agree the proposed coverage is subject to the terms and provisions of the Reinsurer's contract. We have listed above all individuals identified as requested, as of the signature date. The amounts of claim payments on these individuals along with their current status have been indicated. After diligent review, we represent that the above information is complete and accurate. The Reinsurer is entitled to rely upon this information when setting terms and conditions of stop loss coverage as of the effective date; and to the extent such information is inaccurate or incomplete, the Reinsurer reserves the right to rescind coverage as of the effective date, or to adjust the terms and conditions to levels that the Reinsurer would have established if the information provided had been correct; including the right to exclude coverage for any person who should have been identified as a result of this review but was not disclosed herein.

"Diligent review", as it applies here, shall include a thorough review of the current records maintained by the Employer, the Employer's Claim Administrator(s), and the Employer's Utilization Review, Pre-certification and Large Case Management vendors as listed below:

Claims Administrator(s): _____

Case Management Company: _____

Pre-certification: _____

Utilization Review: _____

Accepted by:

By Officer - Employer _____
(Print Name and Title)

By Officer - Employer _____
(Sign Name)

Date: _____

By Officer TPA _____
(As agent of Employer) – Print Name

By Officer TPA _____
(As agent of Employer) – Sign Name

Date: _____